Health Safety Network (HSN)

- **Beginning November 3, 2007 and effective October 1, 2007**, the program formerly called the Uncompensated Care Pool (UCP) or Free Care is now called the Health Safety Network (HSN).
  - The HSN is a fund set up to help pay for health services at **participating hospitals and community health centers** for certain low income individuals with household incomes at or below 44% of the federal poverty level.
  - HSN is not a MassHealth coverage type, but MassHealth determines eligibility for HSN.
- For more information, access Transmittal Letter All 153 from the MassHealth "Provider Library" on www.mass.gov/masshealthpubs. Included in this publication is a crosswalk that matches coverage types from before October 1, 2007, to the coverage types in place after October 1, 2007.
- Additional information can be accessed from www.mass.gov/DHCFP by clicking on the "Health Safety Net" link in the What We Do text box found in the upper left corner of the web page.

HSN Impact to Commonwealth Care

Coverage Type: Commonwealth Care

- REVS is taking the 'guesswork' out of our coverage type
- REVS now displays the different phases of Commonwealth Care coverage
  - CommCare/HSN
  - CommCare/Partl HSN
  - CommCare/Unenrl
  - Commonwlth Care

HSN Impact to Commonwealth Care

- For Plan Types (1 & 2) within 100 days of eligibility enrollment & no MCO enrollment (0 - 200% FPL).

Coverage Type: Limited (Plan Type 1 only) or CommCare/HSN

633 – HSN for hospital/CHC services

634 – Member Must Enroll

635 – HSN Available

HSN Impact to Commonwealth Care

- For Plan Types (3 & 4) within 100 days of eligibility enrollment & no MCO enrollment (200-250% FPL).

Coverage Type: CommCare/PartI

633 – HSN for hospital/CHC services

634 – Member Must Enroll

638 – Partial HSN Available
$41 deductible

– OR –

641 – Partial HSN Available (with alternate HSN deductible)

HSN Impact to Commonwealth Care

- For Plan Types (3 & 4) within 100 days of eligibility enrollment & no MCO enrollment (250-300%).

Coverage Type: CommCare/PartI

633 – HSN for hospital/CHC services

634 – Member Must Enroll

639 – Partial HSN Available $2083 deductible

– OR –

641 – Partial HSN Available (with alternate HSN deductible)

HSN Impact to Commonwealth Care

- For All Plan Types over 100 days of eligibility enrollment & no MCO enrollment.

Coverage Type :CommCare/Unenrl

634 – Member Must Enroll

640 – HSN Not Available

- If a member had Limited/Comm Care coverage, coverage would continue to display as Limited.

HSN Impact to Commonwealth Care

- For Commonwealth Care members that have selected MCO but is pending enrollment for the next month (0-200% FPL).

Coverage Type: Limited (Plan Type 1 only) or CommCare/HSN

621 – Member Enrolled with (MCO). Coverage to begin (mmyy)

635 – HSN Available

HSN Impact to Commonwealth Care

- For Commonwealth Care members that have selected MCO but is pending enrollment for the next month (200-250% FPL).

Coverage Type : CommCare/PartI

621 – Member Enrolled with (MCO). Coverage to begin (mmyy).

638 – Partial HSN Available with 200-250 FPL. $41 deductible

– OR –

641 – Partial HSN Available

HSN Impact to Commonwealth Care

- For Commonwealth Care members that have selected MCO but is pending enrollment for the next month (250-300% FPL).

Coverage Type : CommCare/PartI

621 – Member Enrolled with (MCO). Coverage to begin (mmyy)

639 – Partial HSN Available with 250 - 300 FPL. $2083 deductible

– OR –

641 – Partial HSN Available

HSN Dental Messages

- For members enrolled in a Commonwealth Care Plan Type the following messages will appear:

Plan Type 2 (100 – 200% FPL)

HSN Dental

Plan Types 3 & 4 (200 – 250% FPL)

Partial HSN Dental Available with Deductible Displayed (determined deductible or $41)

Plan Types 3 & 4 (250 – 300% FPL)

Partial HSN Dental Available with Deductible Displayed (determined deductible or $2083)

HSN Impact to Essential & Basic

Coverage Type – Essential

Now Becomes:

- Essential
- Essential/HSN
- Essential/Unenroll

Coverage Type – Basic

Now Becomes:

- Basic
- Basic/HSN
- Basic/Unenroll

To help the financially needy obtain high-quality health care that is affordable, promotes independence, and provides customer satisfaction.

Massachusetts Hospital Association and MassHealth Operations

Work Group Meeting
November 5, 2007

MassHealth

Agenda

- MassHealth Updates
  - newMMIS
  - Tamper Resistant Prescription Pads
- Automated Solutions for MHA
- MassHealth Billing

MassHealth Updates

newMMIS

- MassHealth recently conducted the Fall 2007 Provider Forum Series to provide preliminary information on the newMMIS and how providers could begin preparing for its implementation

- On November 1, 2007, MassHealth hosted a similar session for billing intermediaries and software vendors in order to prepare them to support you through this transition

MassHealth Updates

Tamper Resistant Prescription Pads

As reported in All Provider Bulletin 168, there has been a six month delay for the requirement for tamper-resistant written prescriptions

Now, effective for dates of service on and after April 1, 2008, a prescription pad must contain at least one of the following characteristics:

- Prevent unauthorized copying of a completed or blank prescription form
- Prevent erasure or modification of information written on the prescription by the prescriber
- Prevent the use of counterfeit prescription forms

Exempt from the federal requirement are:

- E-prescriptions, prescriptions received via telephone and faxes
- Prescriptions paid by MCO
- Refills for which the original prescription was filled before October 1, 2007

This new requirement applies to both prescription drugs and over-the-counter drugs prescribed for MassHealth members.

Automated Solutions for MHA

Indicating Your Preferred Communication Method

- To indicate your communication preference, simply go to the MassHealth Web site and in the Online Services box, click on "Provider Preferred Communication Method" link.

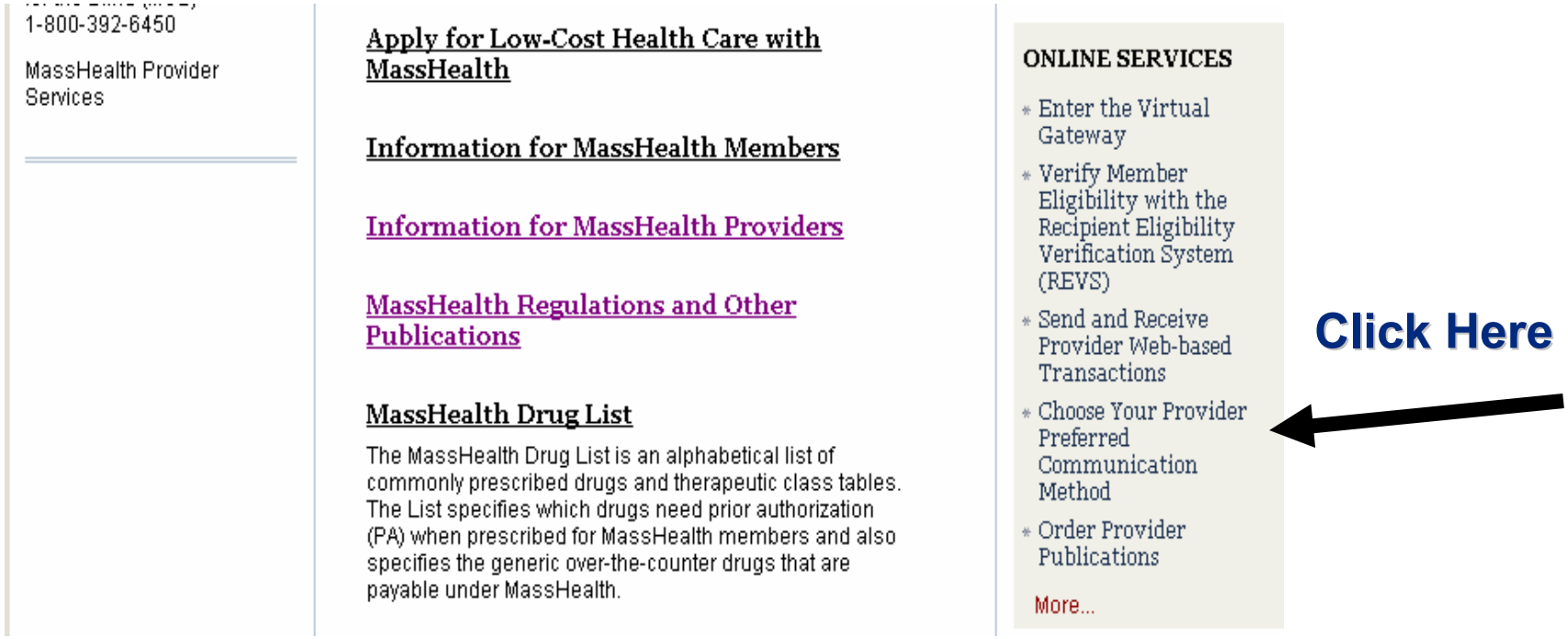
- MHA members who indicated their preferred communication preference increased from 43% to 61%: ↑ **42% since last meeting**

  - Currently, **92%** receive information via email, **6%** receive information via postcard, and **2%** receive hard copy mailings

Automated Solutions for MHA

Indicating your preferred communication method: **Step 1**

Go to www.mass.gov/masshealth



Automated Solutions for MHA

Indicating your preferred communication preference: **Step 2**

Provider Number:

NOTE: If you are organized as a group practice, you must sign up under your group practice provider number.

Contact Name:

Contact Phone Number:

Your E-mail Address:

Confirm Your E-mail Address:

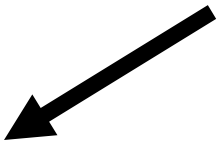
Preferred Communication Method:

e-mail

If the above provider number is a group-practice number, indicate which types of practitioners are in the group. Select all that apply:

- Physician
- Audiologist
- Chiropractor
- Dental provider
- Hearing instrument specialist
- Independent nurse midwife
- Independent nurse practitioner
- Podiatrist
- Psychologist
- Therapist
- Vision care provider

a) Complete Form



b) Hit Send When Complete

Submit Form

Automated Solutions for MHA

Registering for a Customer Service Web Account

- To register for a Customer Service Web Account:
  - Go to www.mass.gov/masshealth
  - Click on "Order Provider Publications" in the Online Services box
  - Fill out the online form, which has space for you to indicate additional users. Then click send.

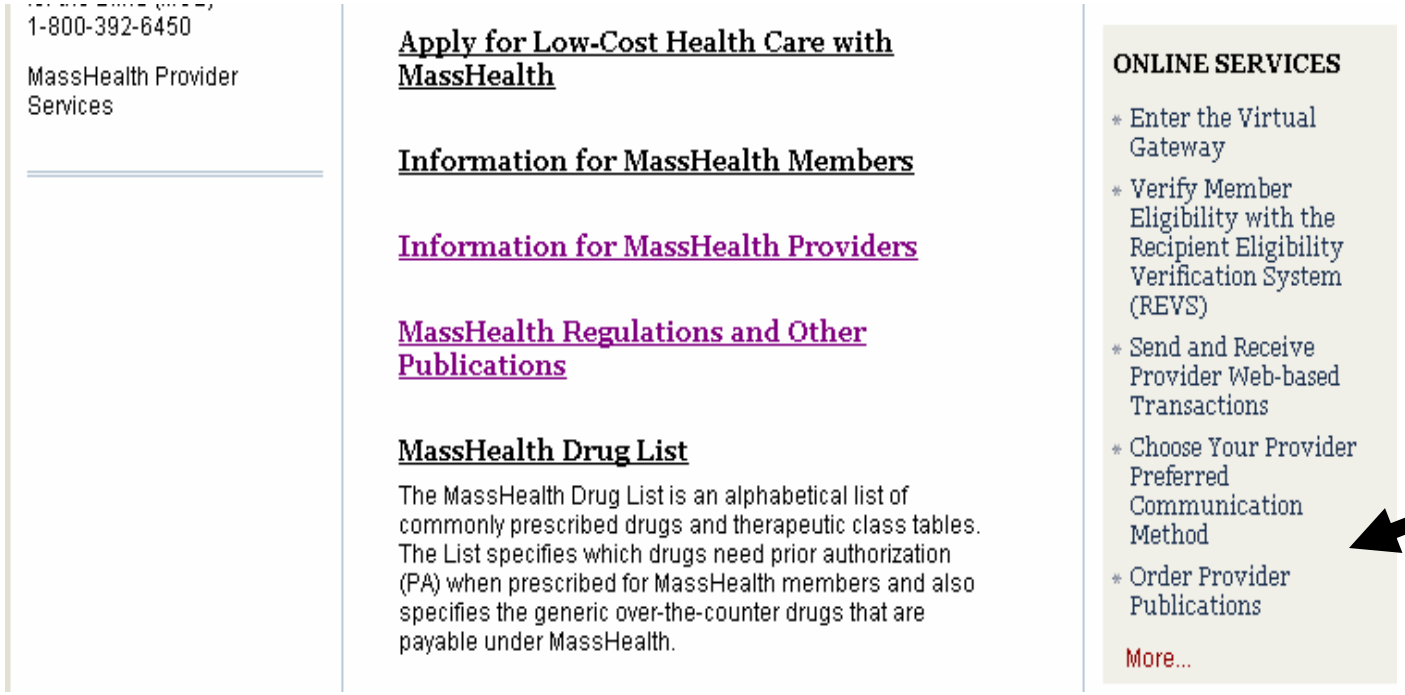
- MHA members possessive of a customer service web account increased from 19.4% to 25%: ↑ **29% since last mtng.**

Please refer to All Provider Bulletin 156 and 157 for additional information on registering for a Customer Service Web Account

Automated Solutions for MHA

Signing up for the Customer Web Portal: **Step 1**

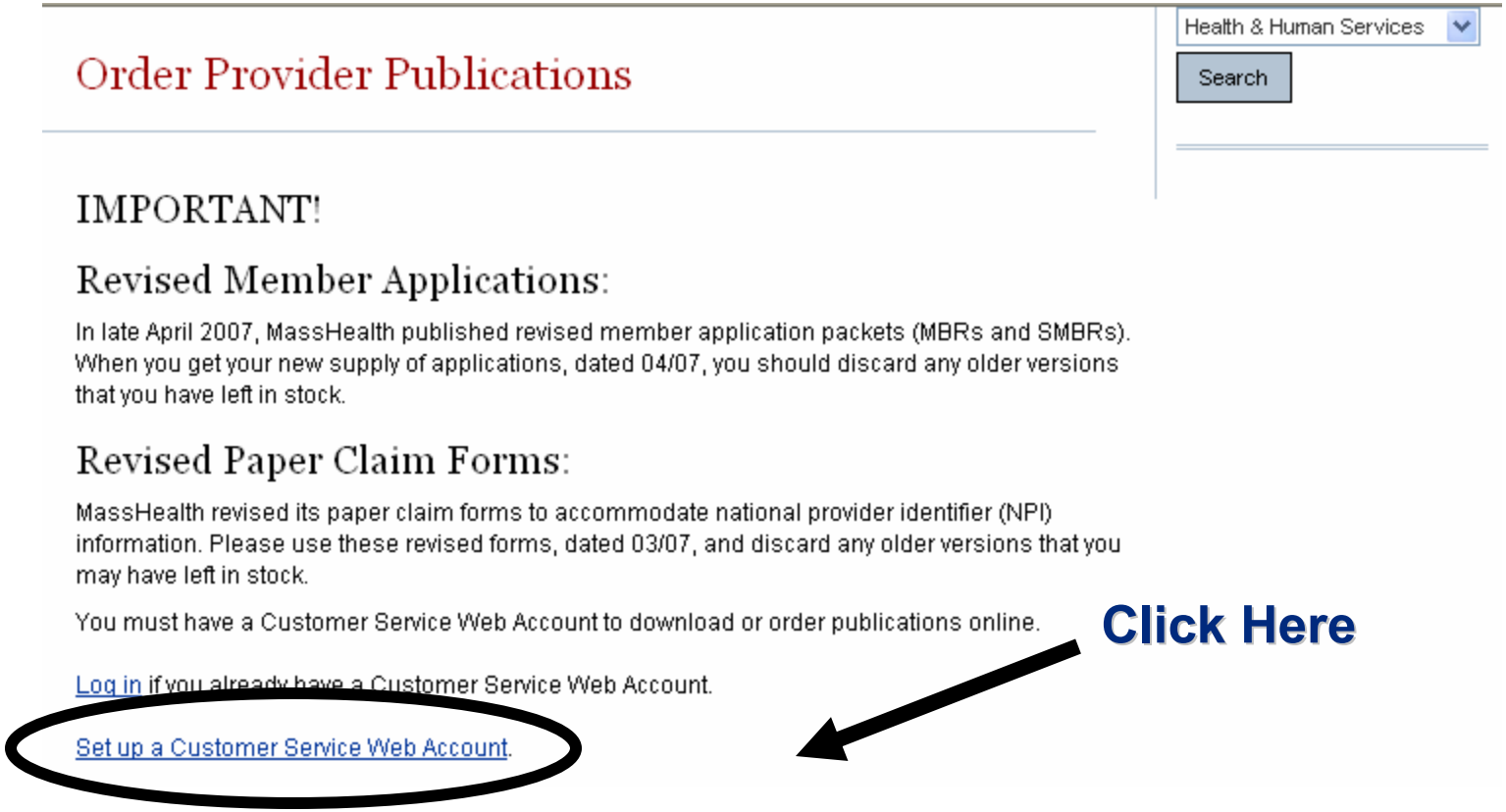
Go to www.mass.gov/masshealth



Click Here

Automated Solutions for MHA

Signing up for the Customer Web Portal: **Step 2**



Automated Solutions for MHA

Signing up for the Customer Web Portal: **Step 3**

Customer Web Portal Account Request Form (This is not a Member Request Form)

Please complete all of Sections 1, 2, and 3. Fields with * are required.

This section may be completed using a group-practice organization provider number or a billing intermediary submitter number.

Enter the contact information for the provider or submitter for whom you are requesting account management access.

First Name * | Last Name * | Title

DBA Name * | Provider or Submitter No. *

Street * | City *

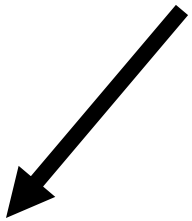
State * | Zip * | Phone No. *

E-mail Address *

Check the appropriate option to indicate the reason for completing and submitting this form.

(•) New account ( ) Add user(s) ( ) Change user access ( ) Deactivate user(s)

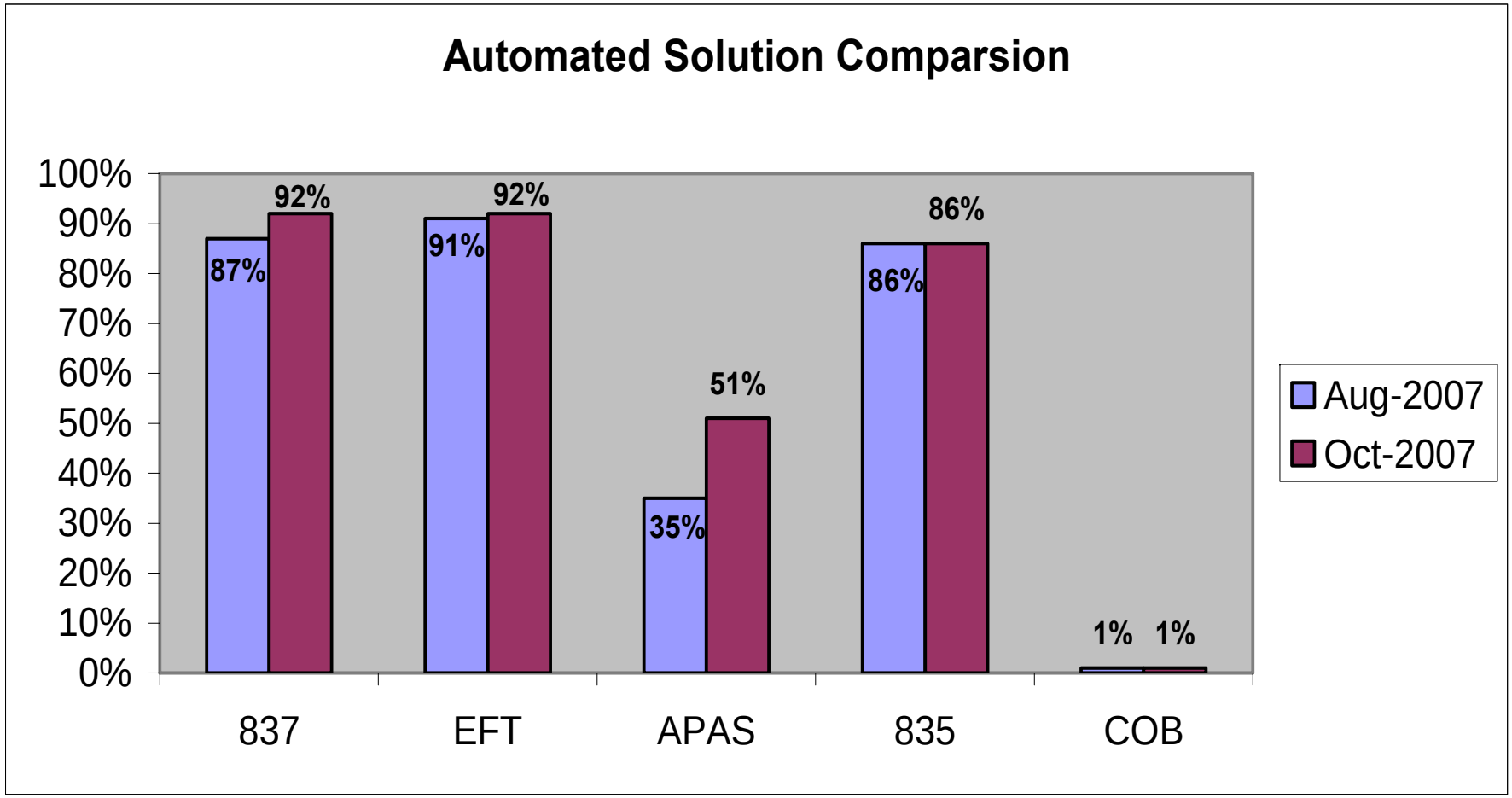
a) Complete Form



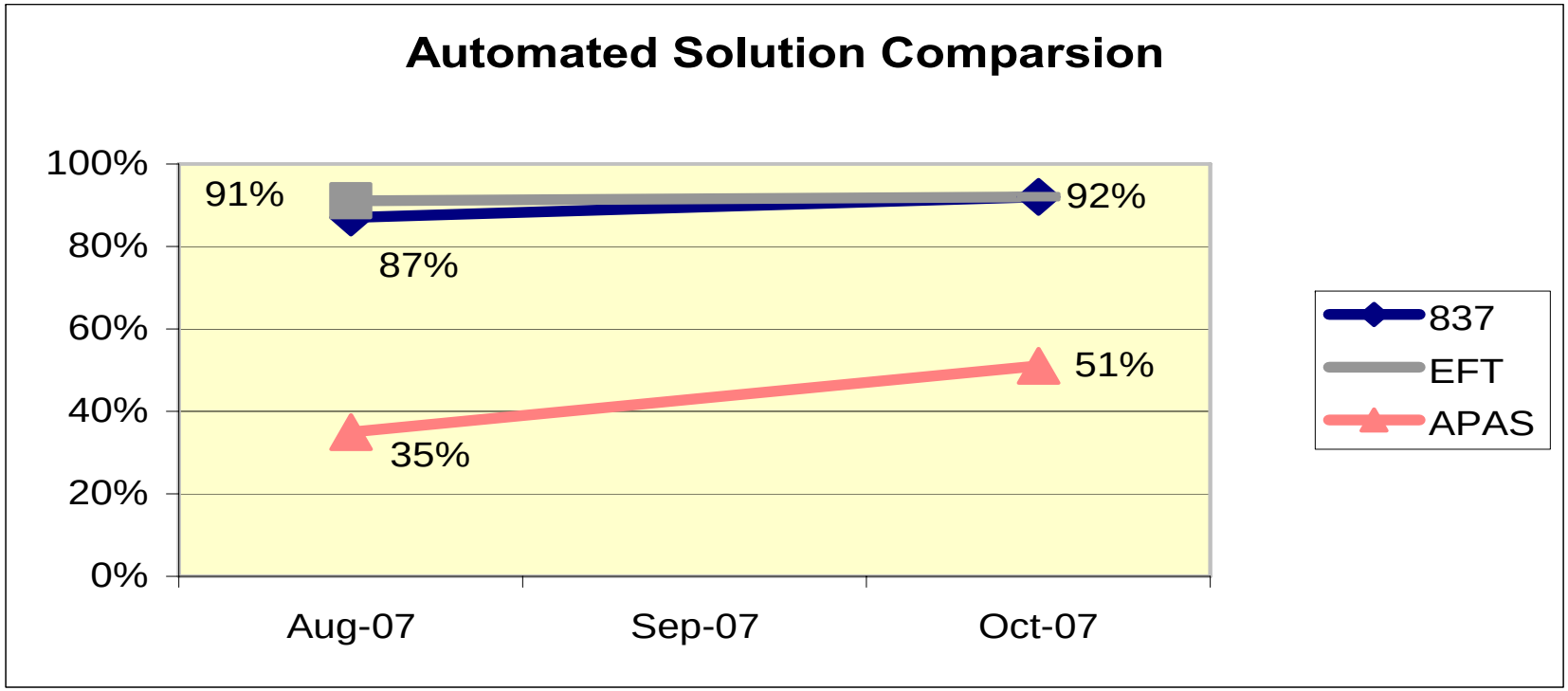
b) Hit Send When Complete

Send | Reset

Automated Solutions for MHA



Automated Solutions for MHA



Increase in providers using 837: 5% increase since August 2007

Increase in providers getting EFT: 1% increase since August 2007

Increase in providers using APAS: 46% increase since August 2007

MassHealth Billing

Coordination of Benefits: First Steps

1. Contact your software vendor or billing intermediary to determine if your system allows you to bill Coordination of Benefits claims

2. If your system can support the 837 COB transaction, obtain information from your vendor or billing intermediary on using your software application to capture this information

3. Create a minimum of 2 or 3 test claims for submission to MassHealth

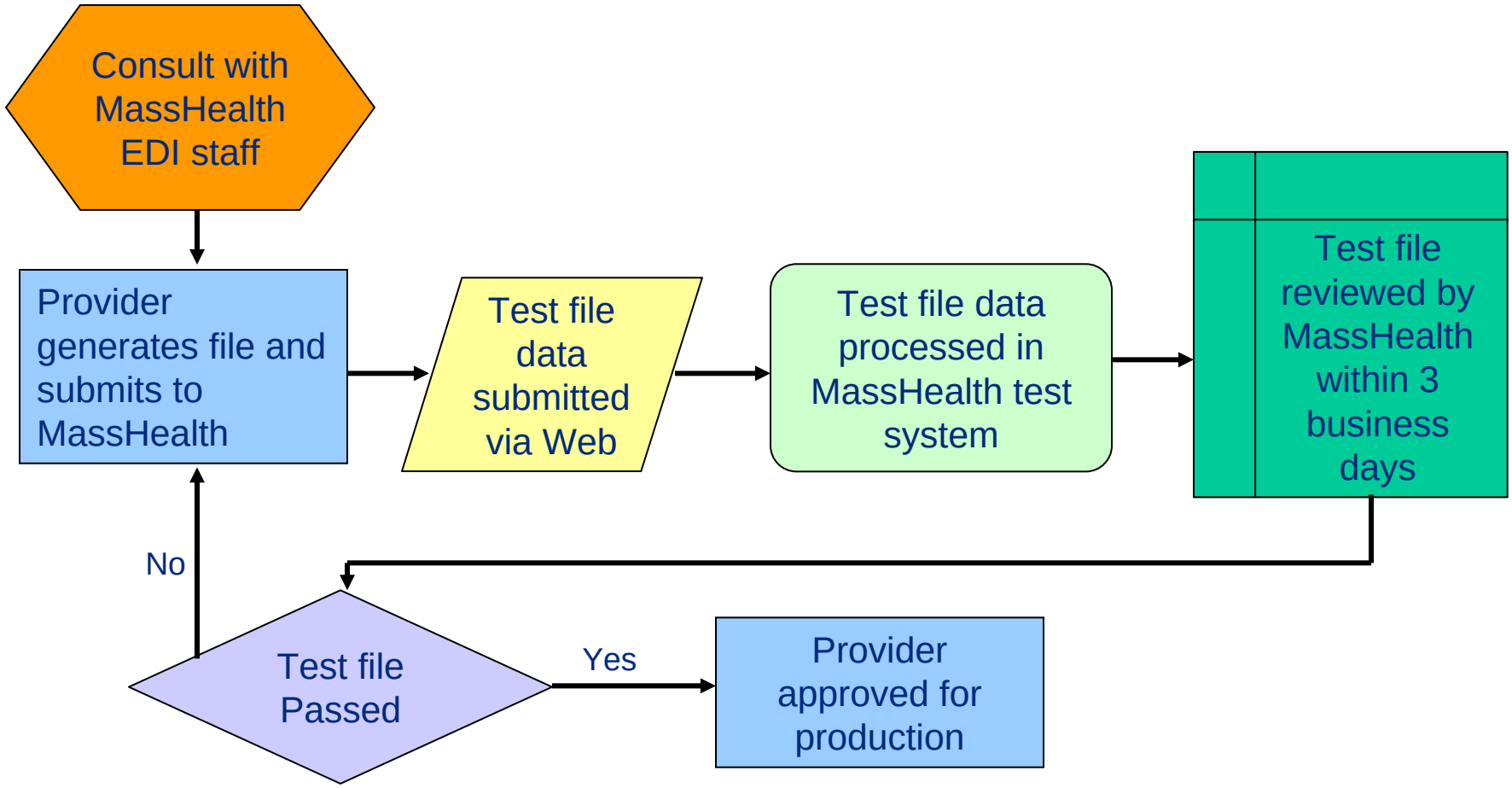
4. Contact MassHealth at 800-841-2900, option 1 and option 4, in order to coordinate your test with MassHealth

5. Send your test transaction to MassHealth

6. If approved, you can begin submitting claims for adjudication to MassHealth. If denied, make the necessary corrections and resubmit your test claims.

MassHealth Billing

Testing is fast and easy



MassHealth Billing

Procedures for the 837 COB Transaction

Use other payer's adjudication details provided on the 835 remittance transaction

- Must enter other payer's adjudication details at the claim line
- Line-level adjudication details are required for outpatient, home health, and hospice
- Adjustment reasons entered in the COB loops must be the same codes given by the other payer (*Note, it is considered fraudulent to alter these codes)

Providers must also enter the MassHealth-assigned carrier code(s) on the 837 to identify the other insurance

- The Recipient Eligibility Verification System (REVS) provides five-digit carrier codes for all applicable insurance coverage for a member
- Enter the first three-digits of other payer(s) carrier code (*Note: the codes entered on the 837I must match the first three-digits of the REVS carrier codes).

The Detail Data for COB Claims table contains loop and segment information

MassHealth Billing

Test and Production COB Files: Detail Data

Loop	Segment		Element Name	Companion Information
2330B	NM1	08	Identification code qualifier	Enter the value “PI” for payer identification.
2330B	NM1	09	Other payer primary identifier	MassHealth assigned three-digit carrier code when NM108 is “PI” (see Appendix C: **Third-Party-Liability Codes** in your provider manual or refer to: mass.gov/MassHealth Provider Library for information.)
2430	SVD		Service Line Adjudication Information	Required if other payer has adjudicated the service line.
2430	CAS		Service Line Adjustment	Required if other payer has not paid in full. All adjustment reason codes given by the other payer must be present.

MassHealth Billing

COB Resources

837 Implementation Guide specifies the required data elements.

- Available at www.wpc-edi.com/hipaa

837I (Institutional) Companion Guide outlines the required MassHealth-specific data elements for test and production 837I files.

- The MassHealth ***Companion Guides*** are available for download from the MassHealth Provider Library, accessible under the "MassHealth Regulations and Other Publications" link on www.mass.gov/masshealth.

The following are MassHealth billing flyers that offer helpful tips for common issues related to COB billing

- **Electronic Coordination of Benefits Billing**
- **How to Correct Error 503**
- **Third-Party Liability**
  - These flyers are located in the "Billing Tips" section under the MassHealth Customer Service for Providers link on www.mass.gov/masshealth

MassHealth Billing

Claims Attachment Form (CAF)

- Claims typically requiring an attachment may be submitted electronically: the claim will suspend for review and a CAF is then mailed to the provider. The provider must return the CAF with the appropriate attachment, and the electronic claim and paper attachment will process together

Instances requiring a CAF:

General Report Required: If the providers claims contain services that are priced on an individual consideration basis, as indicated in subchapter six of the provider manual, then a general written report or discharge summary is required.

Operative Report Required: If the providers claims contain surgical services that are priced on an individual consideration basis, as indicated in subchapter six of the provider manual, then operative notes are required.

Consent for Sterilization Form: If the providers claims are billed for sterilization services, then the consent for sterilization form will be required.

MassHealth Billing

Claims Attachment Form (CAF) Misunderstandings

Myth: CAF Forms are sent to the check mailing address.	→	**Truth**: CAF Forms are sent to the Doing Business As address.
Myth: CAF Forms must be sent back with the attachment and a paper copy of the claim.	→	**Truth**: When responding to CAF forms, only the CAF form and the required attachment are needed.
Myth: If the submission of one claim results in the receipt of multiple CAF letters, then only one CAF letter and one attachment need to be sent back.	→	**Truth**: Do not bundle attachments with one CAF form. Each CAF received should be sent back with the appropriate attachment.

MassHealth Billing

055 – Invalid/Missing # of Days — **10.45% of hospital claims denied during the past 3 months**

The number of days is either missing or invalid.

Resolution: If the number of days has been entered, ensure they were calculated correctly. If the number of days is missing be sure to enter that information in field 7 of the UB-04 paper claim form or in the QTY segment in loop 2300 of the 837I transaction.

103 - Duplicate Claim: — **5.12% of hospital claims denied during the past 3 months**

The claim submitted is a duplicate of a claim previously paid for the same member, pay to provider number, and service date

Resolution: Post claims timely from your remittance advice. Allow 30-45 days for claims to process

484- Coverage is Buy-In/Subsidy Only: — **2.07% of hospital claims denied during the past 3 months**

The service code entered on the claim is not covered for members enrolled in this coverage type. The member has Buy-In/ Subsidy only.

Resolution: Based on eligibility requirements, MassHealth members receive benefits according to specific coverage types. REVS provides the member's coverage type as part of the eligibility verification transaction. Refer to the specific MassHealth regulation at 130 CMR 450.105 for a list of covered services by coverage type and for other information and requirements about each coverage type